HEALTH CARE WASTE AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 9, 1994

Serial No. 103-116

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HEALTH CARE WASTE AND ABUSE

WEDNESDAY, FEBRUARY 9, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 11 a.m., in room 2322, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order.

Over the last several years, this subcommittee has been examining waste, fraud, and abuse in the health care industry and the effectiveness of the existing regulatory frameworks to deal with that matter. Unfortunately, despite extraordinarily good work on the part of the Office of Inspector General at the Department of Health and Human Services, the General Accounting Office, and countless State auditors and investigators, multibillion dollar abuses are still occurring.

Today, we are going to be discussing two issues which cost the taxpayers millions of dollars in double billings, overbillings, and bills that end up being paid out of Medicare's deep pocket, rather than by the primary insurers.

We are particularly delighted to welcome the new Inspector General, Ms. June Gibbs Brown, to this hearing. The subcommittee has had over the years a close and immensely productive relationship with the Office of the Inspector General, and we look forward to our continuing work with that office and with you, Ms. Brown. Your expertise and experience and that of your staff will be critical in the continuing efforts of this subcommittee to protect the taxpayers' concerns and taxpayers' money.

Today, we will focus on two issues. First, the Inspector General has an impressive history of identifying millions of dollars that can only be called hospitals' "slush funds," or in the technical term, "credit balances."

Former Inspector General Richard Kusserow testified before this subcommittee in March 1992, that at least $265 million was resting in hospital coffers as a result of Medicare double billings and overcharges. Even that quarter of a billion dollars was significantly understated, because the analysis only looked at a statistical sampling of 20 percent of the hospitals of this Nation—specifically, those with more than 200 beds and whose bills were paid by 9 of the 56 intermediaries under contract with the Health Care Financing Administration, HCFA.

As we saw then, some hospitals apparently just pocketed the Medicare moneys with little more than a stroke of the pen, when regulations and propriety demanded their return to the taxpayers. Today, Ms. Brown will give us an update on the status of efforts to recoup millions of taxpayers' dollars which are being improperly detained in this fashion.

Second, Ms. Brown will also describe how still nearly a billion dollars is lost when financial intermediaries fail to identify private payers responsible for payment instead of billing Medicare. Unfortunately, this case also illustrates not only a disturbing failure by the fiscal intermediaries, but also by HCFA because both bear responsibility in the failure to see to it that the billing structure and the billings themselves are proper.

It also raises the specter of potential conflicts of interest on the part of the insurance companies who act as intermediaries because, as we have learned in previous hearings, the taxpayers—through HCFA—pay these fiscal intermediaries upwards of $2 billion each year to process Medicare claims and to oversee the appropriate expenditure of taxpayers' money. We have learned that in too many cases the intermediaries have grossly neglected their oversight responsibilities and have deteriorated into little more than claims processors—who, by the way, are paid for their services.

We believe that the Inspector General's success in these matters serves as an impressive and important lesson in the critical role of oversight both in our existing system and in the new health care delivery system which the country is now examining. We look forward to the testimony today of Ms. Brown and to continuing to work closely with her and with her able staff.

Ms. Brown, welcome to the committee.

Ms. BROWN. Thank you.

Mr. DINGELL. The Chair advises that all witnesses who appear here before the committee testify under oath. Do you have any objection to doing so?

Ms. BROWN. None.

Mr. DINGELL. Well, Mr. Hapchuk, are you going to testify also?

Mr. HAPCHUK. Yes, sir.

Mr. DINGELL. Very well. Then, if neither of you have objection to testifying under oath, the Chair notes that you are entitled to be advised by counsel if you so choose. Do either of you desire to do so?

[No response.]

Mr. DINGELL. The Chair also advises that copies of the rules of the subcommittee, rules of the committee, and rules of the House are there at the witness table to inform you of your rights and limits on the powers and prerogatives of the committee.

Does the gentleman from California have an opening statement?

Mr. MOORHEAD. I have an opening statement, Mr. Chairman, but you are on the verge of recognizing the witnesses, so I will ask that it be introduced into the record.

Mr. DINGELL. Without objection, it is so ordered.

[The prepared statement of Mr. Moorhead follows:]

STATEMENT OF HON. CARLOS J. MOORHEAD

Thank you, Mr. Chairman. The subcommittee returns today to the issue of Medicare credit balances, which we last examined at a hearing in March of 1992. It appeared at that time that little was being done to collect the moneys due the Federal Government, and I am anxious to hear whether the efforts to collect have improved.

I want to welcome Ms. Brown to her initial appearance before the subcommittee. The subcommittee has a history of working closely and cooperatively with the HHS Inspector General's Office, and we look forward to continuing in that vein as we seek to rein in the huge amounts of waste, fraud and abuse that are rampant in our health care system.

Thank you, Mr. Chairman.

Mr. DINGELL. Very well, then, Ms. Brown and Mr. Hapchuk, if you will please rise and raise your right hand.

[Witnesses sworn.]

Mr. DINGELL. You may each consider yourselves to be under oath. We are delighted to recognize you for whatever statement you choose to give.

TESTIMONY OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY JOHN HAPCHUK, DIRECTOR OF HEALTH CARE PROGRAM AND OPERATION AUDITS

Ms. BROWN. Good morning, Mr. Chairman and members of the subcommittee. I am June Gibbs Brown, Inspector General for the Department of Health and Human Services, and with me today is John Hapchuk, Director of Health Care Program and Operation Audits.

We are pleased to be here to discuss our work related to Medicare as secondary payer, or MSP, provisions and the hospital credit balance issues. I know these are areas that this subcommittee has followed closely over the years. Problems associated with these issues have resulted in hundreds of millions of dollars being inappropriately spent by Medicare. While we are pleased that recent corrective actions have resulted in substantial recoveries, additional recoveries can still be realized in both areas, and I will outline some ways in this testimony.

Soon after MSP statutes were enacted, our office initiated reviews to assess compliance. Our analysis determined that Medicare was paying upwards of $1 billion annually which should have been paid by private insurers. In addition, we provided audit and investigative support to MSP cases litigated by the Department of Justice. I would like to discuss the MSP area by briefly describing the history of MSP, OIG activity related to MSP, recent MSP corrective action, and additional actions that can be taken.

Medicare was established in 1965 to pay for health care services for eligible beneficiaries 65 and older. Between 1980 and 1986, Congress passed a series of statutory provisions which established Medicare as a secondary payer to private health care insurers. In cases of automobile, no-fault or liability insurance, of certain cases of kidney failure, working beneficiaries age 65 or older or their spouses, and the disabled. Providers are required to bill other insurers first when a beneficiary falls within one of these MSP categories. Medicare contractors who administer the Medicare Program are required to screen all claims for coverage by another insurer.

We began our work in MSP in the early 1980's when we reported that anticipated savings from the initial law pertaining to the employer group health plan coverage was not being realized. We found that in order to preclude the MSP problems Medicare needs to know of private insurance before making payments.

The HCFA agreed with this lack of basic health coverage information and the resulting incorrect Medicare payments were a material internal control weakness and included it in the Secretary's 1989 Federal Managers' Financial Integrity Act report to the President and to the Congress.

The Department continues to report MSP as a high-risk area and as a material weakness. As a result, a number of corrective actions have been implemented or are in the process of being implemented to help identify and recover inappropriate Medicare payment, including (1) an exchange of automated information between Social Security Administration, the Internal Revenue Service, and HCFA; (2) creation of the Medicare and Medicaid coverage data bank to facilitate the identification of other health care insurance coverage; and (3) HCFA's upgrading of the common working file of information concerning other payers and the modification of the Medicare claim forms to obtain additional MSP information.

I would also note that on January 31, 1994, HCFA published guidelines for the reporting of Medicare by private third-party payers. When it is determined that Medicare was improperly paid for the primary service for which the insurer had paid or should have paid, HCFA is also seeking to establish voluntary data exchanges between third-party payers and Medicare.

As far as the OIG activity related to MSP, we have conducted 39 audits and evaluations concerning MSP since March 1984. A list of these reports is contained in the appendix to my written statement. Some reviews examine specific insurance companies to assess their compliance with MSP provisions, and these include: the Provident Insurance Company, Blue Cross and Blue Shield of Michigan, Empire Blue Cross and Blue Shield, and Blue Shield of Florida. We have also assessed the effectiveness of HCFA's implementation of the OBRA 1989 Data Match Project and recommended improvements to HCFA's process to identify potential overpayment.

As to future improvements that could be made, Mr. Chairman, I can tell you that of all of the issues that I have had to become familiar with since becoming Inspector General, MSP is one of the most complicated. HCFA has made progress in identifying improper Medicare payments made on behalf of the Medicaid care beneficiaries who had some other forms of insurance, but we believe that additional corrective action is warranted.

There needs to be current and accurate data bases for health insurance coverage that could be accessed before making a Medicare payment. Insurance companies need to provide HCFA timely, periodic information on insurance coverage.

Also, Medicare contractors should be required to match their private side records with Medicare files to determine instances where Medicare should pay as secondary. We made this recommendation several years ago because of our belief that contractors have a fiduciary responsibility to the Federal Government to assure that only appropriate Medicare payments are made. The OBRA 1989 prohib-

ited HCFA from implementing this matching activity. We continue to believe that this matching is appropriate and consistent with contractor's responsibility to the government.

Also, the MSP provision related to the end-stage renal disease beneficiaries should apply for as long as the employee is covered by an employee group health plan. Such a modification would make the end-stage renal disease provision consistent with other MSP provisions and would result in substantial cost savings for the government.

A Voluntary Disclosure and Recovery Program for MSP would also allow insurers, employees—especially the self-insured and self-administered employers—and employee organizations, or third-party administrators to identify mistaken MSP payments and repay the appropriate amounts with interest.

Now, I would like to speak to hospital credit balances. Our reviews of Medicare and Medicaid hospital credit balances, while they appear to be distinct and separate subjects from MSP, are actually related. This is because some of the deficiencies which cause credit balances to occur are the result of the problems associated with MSP.

A credit balance on a Medicare patient hospital account occurs when the hospital records a higher amount of reimbursement for a particular patient than the charge to Medicare. A credit balance may be due to the hospital billing Medicare and a private insurer for the same service, submitting duplicate billings, billings for services not rendered, or an accounting error.

We analyzed Medicare credit balances at 76 hospitals and 9 fiscal intermediaries to determine if hospitals were identifying Medicare overpayments and refunding them to the fiscal intermediaries. Seventy-one of the 76 hospitals had Medicare overpayments which they had not refunded to Medicare. Based on this sample, we estimated that hospitals owed the Medicare Program about $266 million. There were several causes for these overpayments, and most of them were traceable to the hospitals.

We found that 42 percent of these overpayments were caused by hospital billing Medicare and private insurers for the same service, being reimbursed by both, and keeping both payments. This is precisely the problem associated with the MSP that I discussed earlier in my testimony.

Thirty-seven percent of the overpayments were caused by hospitals submitting duplicate billings for services; 7 percent of the overpayments were caused by hospitals billing for services not performed; 3 percent of the overpayments were caused by the hospitals billing for an outpatient service that was included in the beneficiary's inpatient claim; and 11 percent were caused by miscellaneous errors, for the most part, by fiscal intermediaries.

We also found that some hospitals eliminated the hospital credit balances and kept these overpayments. Although this condition was not widespread among that hospital community, it is nonetheless disturbing because it effectively damages the audit trail and hampers our efforts to determine if the hospital attempted to refund identified Medicare overpayments.

For example, we found that Georgetown Hospital eliminated the credit balances and destroyed the audit trail. As a result of our in-

vestigation, Georgetown agreed to pay the United States a settlement of $2.5 million.

In our report we recommended that HCFA require the fiscal intermediaries to review Medicare credit balance accounts during the hospital audits and that HCFA review the fiscal intermediaries compliance with this requirement during its annual evaluation of the intermediary operation. HCFA agreed with both. As of September 30, 1993, the latest period for which aggregate information is available, HCFA has identified $624 million in Medicare credit balances and recovered over $584 million. We anticipate future annual savings of another $159 million.

Now I would like to speak to Medicaid credit balances. We have had several reviews at selected hospitals of Medicaid patient accounts with credit balances. We performed this last review at the specific request of this subcommittee. Not surprisingly, we found many of the same problems we identified in the Medicare Program.

Our review included 64 hospitals in 8 States, and showed that hospitals were not reviewing their Medicaid credit balances in a timely manner. That resulted in Medicaid overpayments that should have been returned to the Medicaid State agencies. We estimate that, nationwide, hospitals have received and retained $73.4 million in Medicaid overpayments.

We identified several reasons for these credit balances and most of them were attributed to poor hospital accounting practices and mirrored the reasons cited in our review of the Medicare credit balances. In separate reports to the 64 hospitals reviewed, we recommended that they correct problems by establishing procedures to assure that Medicaid credit balances are reviewed and that the overpayments are refunded in a timely manner.

We also issued reports to the eight Medicaid State agencies, recommending that their procedures be implemented for monitoring Medicaid credit balances at hospitals to ensure that Medicaid overpayments are returned, and we recommended that HCFA perform a formal evaluation of the State agencies' oversight activities as to the hospital procedures for Medicaid credit balances. HCFA has agreed to that.

Of the estimated $73 million in Medicaid credit balances outstanding, $31 million are State funds and $42 million are Federal funds. We are now assessing the feasibility of establishing a nationwide credit balance monitoring policy through the Medicaid State agencies. We believe that the MSP and hospital credit balance problems have caused the loss of millions of State and Federal dollars, and we intend to work with HCFA and this subcommittee to identify any additional program losses and recommend future corrective action.

We appreciate the interest of this subcommittee and your continued support to promote our efforts. I would be happy to answer any questions that the subcommittee may have.

[Testimony resumes on p. 35.]

[The prepared statement of Ms. Brown follows:]

JUNE GIBBS BROWN

INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and members of the subcommittee. I am June Gibbs Brown, Inspector General for the Department of Health and Human Services. Although I have a long history with the Inspector General community, this is my first appearance before this subcommittee since joining HHS. With me today is George M. Reeb, Assistant Inspector General for Health Care Financing Audits. We are pleased to be here to discuss our work related to the Medicare as secondary payer (MSP) provisions and hospital credit balance issues. Over the years both these areas have experienced problems resulting in hundreds of millions of dollars being inappropriately spent by Medicare. We are pleased that recent corrective actions taken in these areas have resulted in substantial recoveries. The Health Care Financing Administration estimates that it has recovered $584 million in hospital credit balances. Substantial additional recoveries can be realized in both areas, and I will outline some of the ways in this testimony.

INTRODUCTION

The Office of Inspector General (OIG), created in 1976, is charged with protecting the integrity of departmental programs as well as promoting their economy, efficiency, and effectiveness. Our audit, investigations and inspections activities are well known to this subcommittee. Last year, the Office generated savings, fines, restitutions, penalties, and receivables of over $61 for each Federal dollar invested in its operation. In addition, 1,406 successful prosecutions and 956 administrative sanctions (in the form of program exclusions and civil monetary penalties) were obtained.

Over the years, the Medicare program has seen many significant reforms, many of which resulted from issues brought to light by the OIG. As Medicare reforms were instituted, we used our resources to evaluate the effectiveness of these changes and to make recommendations for further modifications. Such reforms include implementation of a prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services, the Clinical Laboratory Improvement Amendments of 1988, regional consolidation of claims processing for durable medical equipment (DME), establishment of fraud units at Medicare contractors, prohibition on Medicare payment for physician self-referrals, and new payment methodologies for graduate medical education.

We are also very active in analyzing the cost-effectiveness of services delivered. Over the years, we have documented excessive payments with respect to hospital services, indirect medical education (IME) payments, durable medical equipment, and laboratory services. In many cases, our recommendations have lead to statutory changes to reduce payments in these areas. Through these activities, we have sought to ensure that program dollars are spent without undo waste and that the financial viability of the trust funds is maintained.

Of equal importance to us is that the beneficiaries of our programs receive high quality care. Over the years, the OIG has assessed clinical and physiological laboratories, the medical necessity of certain services and medical equipment, and various State licensure and discipline issues.

We also evaluate the adequacy of internal controls that are in place to prevent losses to fraud, waste, and abuse. Further, the OIG plays an active role in the Department's Federal Manager's Financial Integrity Act (FMFIA) which detects and corrects systemic weaknesses. In addition, we are actively involved in reviewing the financial statements issued by the Health Care Financing Administration (HCFA) as part of the Chief Financial Officer's Act of 1988.

Our investigative role helps to ensure that beneficiaries receive high quality care at appropriate payment levels. We utilize three enforcement authorities: (1) criminal prosecution, (2) civil prosecution, and (3) administrative sanctions (which include both program exclusions and civil monetary penalties). All investigations can result in one or more of these remedies being employed. We refer investigative findings directly to the United States Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or declined a criminal case and declined civil prosecution, HHS can impose civil monetary penalties (CMPs) pursuant to the Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a. The OIG is also responsible for implementing the Secretary's authority for excluding fraudulent or abusive providers from participation in Federal health care financing programs. Thus the activities of our office consist of a multi-faceted approach to improving the management of the Department's programs and protecting the beneficiaries from fraud, waste, and abuse.

MEDICARE AS SECONDARY PAYER

The two issues that we are here to discuss today, MSP and credit balances, illustrate the diverse approach that the OIG brings to the issues facing the Department. Soon after the MSP

statutes were enacted, our office initiated reviews to assess compliance with the statutes. Our analyses determined that Medicare was paying upwards of a billion dollars annually which should have been paid by private insurers. Our reviews also identified deficiencies in internal management controls and led to the identification of MSP as a material weakness. In addition, we have provided audit and investigative support to MSP cases litigated by the Department of Justice (DOJ).

Our analyzes of these problems have led to corrective action and reforms to how Medicare identifies beneficiaries with other health insurance. As a result of the OBRA 1989 data match alone, HCFA estimates that at least $85 million has already been collected. Potential additional recoveries are substantial. We are now in the process of reviewing whether corrective taken to date is sufficient to correct the problems associated with MSP. We are concerned that additional action will be required to have a current, accurate data base of health insurance coverage that could be accessed before making the Medicare payment.

I would like to discuss the MSP area by briefly describing: (1) the history of MSP; (2) OIG activity related to MSP; (3) recent MSP corrective action; and (4) future improvements that could be made.

HISTORY OF MSP

Medicare was established in 1965 to pay for health care services for eligible beneficiaries age 65 and older. For the first 15 years of this program, Medicare was the primary or first payer

for all health claims except when the claimant was covered by workers' compensation, black lung, or veterans benefits. Between 1980 and 1986, Congress passed a series of statutory provisions which established Medicare as the secondary payer to other private health care insurers in certain situations. In general, Medicare is a secondary payer to:

- Coverage under an automobile, no-fault or liability insurance plan.

- Employer group health plan (EGHP) coverage of beneficiaries who have kidney failure (end stage renal disease) during their first 18 months of Medicare entitlement.

- Coverage under an EGHP (provided by an employer of 20 or more persons) of working beneficiaries age 65 or older or their spouses.

- Coverage under an EGHP provided by an employer of 100 of more persons based on the current employment of disabled beneficiaries and their family members.

Under current procedures, health care providers are required to ask a Medicare beneficiary a series of questions concerning health insurance coverage when the beneficiary is admitted to the hospital or when any other medical service is rendered. Providers are required to bill other insurers first when a beneficiary falls within one of the MSP categories.

Medicare contractors, who administer the Medicare program, are required to screen all claims for coverage by another insurer. This is done by searching history files; querying the common

working file (CWF), which is Medicare's central claims processing file; and contacting beneficiaries directly to develop information such as accident liability and other insurance information. The 1994 departmental budget includes $101.2 million for MSP contractor-related activities and about $3.6 billion in savings are expected from these activities.

RECENT MSP CORRECTIVE ACTION

We began our work in MSP in the early 1980s when we reported that anticipated savings from the initial law pertaining to EGHP coverage were not being realized. We found that in order to solve the MSP problem, Medicare needs to know of private insurance before making payments. The HCFA agreed that this lack of basic health coverage information and the resulting incorrect Medicare payments were a material internal control weakness and included it in the Secretary's 1989 Federal Managers' Financial Integrity Act report to the President and the Congress. The Department continues to report the MSP issue as a high risk area and as a material weakness.

As a result, a number of corrective actions have been implemented or are in the process of being implemented to help identify and recover inappropriate Medicare payments:

- The Omnibus Budget Reconciliation Act (OBRA) of 1989 authorized an exchange of automated information between the Social Security Administration (SSA), Internal Revenue Service (IRS), and HCFA. These computer data exchanges enable the identification of working beneficiaries and/or beneficiaries with working spouses. These

exchanges also enable HCFA to contact employers to obtain health insurance coverage information. (OBRA 1990 and OBRA 1993 extended this provision through September 30, 1998.) HCFA conservatively estimates that hundreds of millions of dollars were inappropriately paid by Medicare between 1987 through 1989 due to not knowing the beneficiaries had other insurance coverage. Through case development actions, HCFA reports indicate that collections of these potential inappropriate payments to date have amounted to at least $85 million.

- The OBRA 1993 also authorized creating the Medicare and Medicaid coverage data bank to facilitate the identification of other health insurance coverage. The data bank could be used to further the MSP initiatives and will also assist in the identification of third-party liability situations in the Medicaid program. The HCFA is currently in the process of designing the data bank's specifications.

- HCFA continues to upgrade the common working file (CWF) for updating and storing of information concerning other payers. If another payer is indicated on the CWF and Medicare is billed as primary, the claim is denied and returned to the provider along with instructions to bill the other payer as primary. All Medicare contractors are currently connected to the CWF. We plan to review the system to assure that applicable claims are, in fact, identified and processed correctly.

- Medicare claim forms are in the process of being modified to obtain additional MSP information. This information is also being used to update the CWF MSP file. We plan to review selected claims to assure that data is correctly annotated on the CWF.

- Currently, Medicare contractors send out questionnaires upon receipt of a beneficiary's first claim. The questionnaire attempts to identify the existence of other insurance coverage. The initial enrollment questionnaire process (to be implemented this fiscal year) will enhance MSP compliance by seeking to identify insurance information at the time a beneficiary becomes eligible for Medicare. We plan to review whether the questionnaires are sent to all "new enrollees" and that their replies are correctly sent to the CWF.

OIG ACTIVITY RELATED TO MSP

We have conducted 39 separate audits and evaluations concerning MSP since March 1984. A list of these reports is contained in Appendix B. I would like to briefly describe some of our more recent work in this area. Because MSP is so complex, I have segregated these reviews into three types: (1) specific insurance company reviews, (2) data match project reviews, and (3) Medicare contractor reviews.

Specific Insurance Company Reviews - We have conducted a series of reviews which evaluated specific insurance company' implementation of the MSP provisions . These reviews

focused on the amount of MSP liability to the Medicare program because MSP situations went undetected. This HCFA postpayment recovery work is known as the "pay and chase method."

- We issued a report in December 1993 on Provident Insurance Company (A-04-92-02049). The DOJ and HCFA, with assistance from our audit staff, recently settled its MSP recovery case against this private insurance company. As part of the settlement, Provident agreed to pay $27 million to the Medicare program and to assist in identifying additional improper Medicare payments made to providers.

- We issued a memorandum to HCFA in March 1993 on Blue Cross and Blue Shield of Michigan (A-05-92-00099), which is another MSP recovery case being litigated by DOJ. This case and our associated audit work are ongoing, and we will issue a report when completed. A significant amount of potential incorrect Medicare payments are being reviewed.

- As noted in our Spring 1993 semiannual report, we issued a memorandum (A-02-91-01054) alerting HCFA to the preliminary results of a review they requested on Empire Blue Cross and Blue Shield. Our review is almost complete and we believe that a significant amount of overpayment may have been made. We plan to issue a draft report soon.

- We issued a final report in April 1992 on Blue Shield of Florida (A-04-91-02004). This review identified about $19 million of potential overpayment which should be recovered.

Each of the last three insurance companies I mentioned is also a Medicare contractor, under contract with HCFA, to administer the Medicare program.

Data Match Project Reviews - As previously discussed, OBRA 1989 mandated the sharing of information between the IRS, SSA, and HCFA to facilitate the identification of other insurance coverage. This process requires fiscal intermediaries and carriers to contact identified employers to determine what periods the employee or employee's spouse were covered under an EGHP and the nature of the coverage. We have conducted several reviews to monitor the effectiveness of HCFA's implementation of this data match project:

- In August 1992, the OIG issued a report, *Medicare as a Secondary Payer - Review of the HCFA's Efforts to Implement the Data Match Project* (A-09-91-00103), which recommended various improvements that would enhance HCFA's ability to identify potential overpayments.

- We are currently working on a draft report entitled *Follow-up Audit of HCFA's Resolution of OIG Recommendations Relating to Employer Compliance with the MSP Data Match Project* (A-02-93-01017). This review will analyze the extent to which

employers have complied with requests for information on the health insurance of their employees.

Medicare Contractor Reviews - We have conducted numerous reviews to determine the overall effectiveness of Medicare contractors in implementing the MSP provisions. The following briefly describes some of the more current work we have conducted in this area:

- In November 1991, we issued a report entitled *Medicare Secondary Payer: Effectiveness of First Claim Development* (OEI-07-90-00763). We found first claim development by Medicare contractors to be generally effective in identifying primary payment sources.

- In an August 1991 report, *Extent of Unrecovered Medicare Secondary Payer Funds* (OEI-07-90-00760), the OIG identified $637 million Medicare inappropriately paid in 1988 because current MSP procedures failed to detect all cases when a beneficiary is covered by a private health insurance policy.

- In another August 1991 report, *Medicare Secondary Payer: Effectiveness of Current Procedures* (OEI-07-00761), we found that Medicare contractors were not coordinating with their private insurance operations, and that carriers and fiscal intermediaries were not coordinating with each other.

FUTURE IMPROVEMENTS THAT COULD BE MADE

Mr. Chairman, I can tell you that of all the issues that I have had to become familiar with since becoming Inspector General, MSP is one of the most complicated. The problems associated with this area have been around for years and if there were any simple solutions we would have corrected the problem a long time ago. Since problems were first identified, there have been significant steps taken to correct the problems. To date, all of the corrective action have not been implemented, and we will have to conduct additional reviews to determine if these actions have been effective.

HCFA has made great progress in identifying improper Medicare payments made on behalf of Medicare beneficiaries who had some other form of insurance. In addition, the data bank of health insurance information established by OBRA 1993 should improve HCFA's ability to identify primary payers. However, we have concerns that this action will not dramatically improve the MSP problem because of the historical nature of the insurance coverage data. Therefore, we believe that additional corrective action is warranted:

- We believe that a need remains to have a current, accurate data base of health insurance coverage that could be accessed before making the Medicare payment. There remains a need for insurance companies to provide to HCFA timely, periodic information on insurance coverage. We will, however, review HCFA's actions to implement the new OBRA 1993 data bank to determine if significant improvement in avoiding incorrect Medicare payments results.

- We also believe that Medicare contractors should be required to match their private side records with Medicare files to determine instances where Medicare should be secondary. Several years ago, we made this recommendation. This recommendation was based on our belief that contractors have a fiduciary responsibility to the Federal Government to assure that only appropriate Medicare payments are made. It follows that contractors, by failing to match their private insurance files with Medicare files, are breaching this responsibility. The OBRA 1989 prohibited HCFA from requiring this matching activity. We continue to believe that this matching activity is appropriate and consistent with the contractor's fiduciary responsibility to the Government.

- We also believe that the MSP provision relating to ESRD beneficiaries should apply for as long as the employee is covered by an EGHP. Currently, Medicare is secondary only for the first 18 months of a beneficiaries entitlement to Medicare. Such a modification would make the ESRD provision consistent with the other MSP provisions and would result in substantial cost savings.

- We are reviewing the feasibility of establishing a Voluntary Disclosure and Recovery Program for MSP which would allow insurers, employers (especially self-insured and self administered employers), employee organizations, or third-party administrators to identify mistaken MSP payments and repay the appropriate amounts (with interest). We had recommended the creation of such a program in a February 1990 report which also proposed authorizing an additional administrative sanction of up to treble damages (plus

interest) where Medicare made a primary payment when third party payers were obligated to make primary payment and did not do so.

HOSPITAL CREDIT BALANCES

I would now like to discuss our reviews of Medicare and Medicaid credit balances. While hospital credit balances and MSP appear to be distinct and separate subjects, they are actually related. This is because some of the deficiencies which cause credit balances to occur are the result of problems associated with MSP. Let me explain in more detail.

A credit balance on a Medicare patient hospital account occurs when a hospital records a higher amount of reimbursement for a particular patient than the amount charged to the patient. A credit balance may be due to a hospital billing Medicare and a private insurer for the same service (thus developing a potential MSP situation), submitting duplicate billings, billing for services not rendered, or an accounting error. Hospitals should review every Medicare credit balance account to identify Medicare overpayments to be refunded.

MEDICARE CREDIT BALANCES

In a December 1992 report, we analyzed Medicare credit balances at 76 hospitals and 9 fiscal intermediaries to determine if hospitals were reviewing Medicare credit balance accounts to identify Medicare overpayments, and refunding the overpayments to the fiscal intermediaries. (Individual reports were issued to each of the hospitals and fiscal intermediaries and a complete

listing is included in Appendix A.) An earlier report issued on August 29, 1991 had first alerted HCFA to problems with hospitals not returning incorrect Medicare payments in a timely manner. Using statistical sampling techniques, we estimated that hospitals owed the Medicare program about $266 million. These were Medicare overpayments that were recorded on hospitals' accounting records as Medicare credit balances, but had not been refunded to the fiscal intermediaries.

There were several causes for these overpayments and most of them were traceable to the hospitals. We found that:

- 42 percent ($113 million) of these overpayments were caused by hospitals billing Medicare and a private insurer for the same service, being reimbursed by both, and keeping both payments. This is precisely the problem associated with MSP 1 discussed earlier in my testimony.

- 37 percent ($98 million) of the overpayments were caused by hospitals submitting duplicate billings for services. Most of the claims went undetected by the fiscal intermediaries because hospitals used different procedure codes, or dates of service for the same service.

- 7 percent ($19 million) of the overpayments were caused by hospitals billing for services not performed. This typically occurred when hospitals mistakenly anticipated that a service would be performed, but was not because of some unforeseen

circumstance. When the hospitals became aware that the service was not performed, they canceled the charges, thus creating a Medicare credit balance.

- 3 percent ($6.6 million) of the overpayments were caused by the hospitals billing for an outpatient service that was included in a beneficiary's inpatient claim. Medicare regulations require that any outpatient service performed within a certain number of days prior to admission is to be included on the inpatient bill.

- 11 percent ($29 million) of the overpayments were caused by miscellaneous errors made, for the most part, by fiscal intermediaries. For example, we found errors in calculating the deductibles and co-insurance amount, incorrect diagnosis related group codes, and payments made for noncovered services.

The primary reason these overpayments were not refunded to the fiscal intermediaries was that hospitals were not reviewing their Medicare beneficiary accounts with credit balances to determine if the credit balances were caused by Medicare overpayments. However, we also determined that fiscal intermediaries were not always recovering overpayments even when hospitals attempted to refund them. Fifty-two of the hospitals included in our review unsuccessfully attempted to refund some Medicare overpayments to eight of the nine fiscal intermediaries. HCFA has since issued instructions to the fiscal intermediaries on recouping credit balances; and this situation, to our knowledge, no longer occurs.

We also found that some hospitals wrote-off from their accounting records Medicare beneficiary accounts with credit balances, and kept the overpayments. Although this condition was not a widespread practice among the hospital community, it is, nonetheless, disturbing because it effectively damages the audit trail and hampers efforts to determine if a hospital attempted to refund identified Medicare overpayments. For example, during the early stages of our review at Georgetown University Hospital, it was apparent that the number of Medicare accounts with credit balances was not consistent with either the size of the hospital or the Medicare utilization. Through discussions with Georgetown officials and the review of prior years credit balance accounts, it was determined that Georgetown had eliminated the credit balance and destroyed the audit trail. An investigation was conducted which involved our OIG audit and investigation offices and the DOJ. In late December, Georgetown agreed to pay the United States $2.5 million.

In our reports, we recommended that HCFA require the fiscal intermediaries to review Medicare credit balance accounts during their hospital audits. In addition, HCFA should review the fiscal intermediaries' compliance with this requirement during its annual evaluation of fiscal intermediary operations. The HCFA's response was overwhelmingly positive. Not only did it agree with both of our recommendations, but action was taken to recover Medicare overpayments from hospitals. The HCFA instructed the fiscal intermediaries to contact all providers and require them to report Medicare credit balances on a quarterly basis. This action has resulted in substantial recoveries to the Medicare program. As a result of the actions taken, as of September 30, 1993, the latest period for which aggregate information is available.

$624 million in Medicare credit balances have been identified and over $584 million recovered. We anticipate future annual savings of $159 million for Medicare.

MEDICAID CREDIT BALANCES

Mr. Chairman, I would now like to discuss our reviews at selected hospitals of Medicaid patient accounts with credit balances. We performed this review at the specific request of this subcommittee. The primary objective of our review was to determine if hospitals were reviewing Medicaid credit balance accounts to identify Medicaid overpayments, and refunding the overpayments to their State agencies as required by law. Our review at 64 hospitals in 8 States showed that hospitals were not reviewing their Medicaid credit balances in a timely manner, resulting in Medicaid overpayments that should have been returned to the Medicaid State agencies. We estimate that, nationwide, hospitals have received and retained over $73 million in Medicaid overpayments. We identified several reasons for these credit balances, and most of them were attributable to poor hospital accounting practices and mirrored the reasons cited in our review of Medicare credit balances.

- 54 percent of the Medicaid credit balance total resulted from hospitals billing Medicaid and third parties, such as a commercial insurer or Medicare, for the same services, receiving primary payments from both, and keeping both payments. When the hospitals received payments from both insurers, they established credit balances for the excess reimbursements, but did not always resolve the credit balances. We found that the

other insurer was primary and that the Medicaid payments were overpayments to the hospitals.

- 25 percent resulted from hospitals submitting duplicate claims for services which were both paid by the State agencies. Most of the claims went undetected because hospitals submitted duplicate claims using different procedure codes or dates of service for the same service. Examples of these duplicate payments include: hospitals submitting a bill, not receiving a payment on the next payment voucher, submitting a second bill, and then receiving payments for both bills submitted; hospitals billing charges both by component and in total; and hospitals mistakenly processing payment tapes twice. Also, we found that some hospitals billed individually for services performed at different times and then submitted a bill for the aggregate amount.

- 21 percent resulted from reasons such as billing errors, payments for services not performed, and other hospital accounting errors.

In separate reports to the 64 hospitals reviewed, we recommended that hospitals establish procedures to assure that Medicaid credit balances are reviewed and that overpayments are refunded in a timely manner. We also issued reports to the eight Medicaid State agencies recommending that procedures be implemented for monitoring Medicaid credit balances at hospitals to ensure Medicaid overpayments are returned.

In our report issued March 31, 1993, we recommended that HCFA perform a formal evaluation of the State agencies' oversight activities of hospitals' procedures over Medicaid credit balances and the timely refunding of overpayments. We also recommended that HCFA increase its monitoring of State agencies' activities to reduce overpayments in the areas of primary payer issues and duplicate payments.

The HCFA agreed with our recommendation to perform an evaluation of the State agencies' oversight activities of hospitals' procedures over Medicaid credit balances and the timely refunding of overpayments. In addition, HCFA has issued a guide for its staff reviewing credit balances in hospital Medicaid accounts and has also issued a directive to its regional offices to emphasize to the State agencies the need for identifying and adjusting credit balances on a continuing basis. The regional offices were directed to conduct reviews, as circumstances warrant and resources permit, to determine the extent and quality of States' efforts in meeting their oversight responsibilities.

Mr. Chairman, we believe it is essential that Medicaid credit balances be identified and the associated overpayments be returned to the Medicaid State agencies. If this is not done, both the Federal and State governments lose. Of the estimated $73 million Medicaid credit balances outstanding, $31 million are State funds and $42 million are Federal funds. We believe it is in the States' best interest to work with the Federal Government to ensure that this problem is resolved. We anticipate future annual savings to total $44 million annually ($25 million Federal share and $19 million State share).

Therefore, we are currently performing a review to assess the feasibility of establishing a nationwide credit balance monitoring policy through Medicaid State agencies. To that end, we mailed letters to the 50 State agencies in November 1993 requesting that they provide us with information regarding efforts made and procedures followed for identifying and recovering overpayments. We have received responses from 29 of the 50 state agencies. We are now in the process of analyzing these responses.

CONCLUSION

The Office of Inspector General in conjunction with HCFA continues to set ambitious goals to promote economy and efficiency in Federal health programs. We believe that beneficiaries should receive quality care, that the integrity of the trust funds should be maintained and that those individuals that defraud the Department's programs should be held responsible for their actions. The two issues that we have discussed today, MSP and hospital credit balances, are examples of weaknesses in our programs that have caused the loss of millions of dollars. With the actions of our office, HCFA and this subcommittee, corrective action has been taken to recover program losses and to prevent future losses. We will continue to monitor this corrective action to ensure that these changes have been effective. We appreciate the interest the subcommittee has in this area and your continued support to promote our efforts.

I would be happy to answer any questions that the subcommittee may have.

SUMMARY RESULTS
BY
HOSPITAL

Intermediary / Hospital		Medicare Overpayment
1.	**Independence Blue Cross** *	
1.	St. Joseph's	$ 0
2	St. Agnes Medical Center	0
3.	Albert Einstein Medical Center	231,283
4.	Temple University	64,204
5.	Magee Rehabilitation	8,059
6.	Eagleville	0
7.	Lawndale Community	1,174
8	Warminister	244
9.	North Penn	14,096
10.	Delaware Valley Memorial	2,053
11.	Southern Chester	3,422
Intermediary Total		$ 324,535
2.	**Blue Cross and Blue Shield of Connecticut**	
12.	Yale New Haven	364,334
13.	Norwalk	386,857
14.	Danbury	81,565
15.	St. Vincent's Medical Center	36,070
16.	Greenwich Hospital Association	84,066
17.	St. Mary's	31,540
18.	Stanford	529,966
19.	Griffin	175,144
Intermediary Total		$1,689,542
3.	**Blue Cross and Blue Shield of New Jersey**	
20.	Atlantic City	94,622
21.	Overlook	142,486
22.	Christ	139,008
23.	United Hospital of Newark	76,521
24.	St. Clair Riverside Medical Center	30,228
25.	Our Lady of Lourdes Medical Center	246,656
26.	Kimball Medical Center	700,178
27.	Medical Center at Princeton	103,719
Intermediary Total		$1,533,418

* Intermediary judgmentally selected. The 11 hospitals serviced by this intermediary were randomly selected.

4.	**Blue Cross and Blue Shield of Maryland**	
28.	Johns Hopkins	$ 572,504
29.	Washington Hospital Center	227,465
30.	Harbor Hospital Center	284,024
31.	Suburban Hospital Association	36,432
32.	Anne Arundel General	8,170
33.	Washington County	63,593
34.	Liberty Medical Center	162,085
35.	Frederick Memorial	62,835
36.	The Hospital**	0
Intermediary Total		$1,417,108
5.	**Blue Cross and Blue Shield of South Carolina**	
37.	Spartenberg Regional Medical Center	15,568
38.	Baptist Medical Center at Columbia	294,846
39.	Roper	54,294
40.	Mc Leod Regional Medical Center	40,081
41.	St. Francis Xavier	70,578
42.	Trident Regional Medical Center	84,519
43.	Lexington Medical Center	34,912
44.	Tuomey Regional Medical Center	26,826
Intermediary Total		$ 621,624
6.	**Blue Cross and Blue Shield of Wisconsin**	
45.	Meriter	14,297
46.	St. Francis	245
47.	Sinai Samaritan	72,218
48.	Trinity Memorial	14,134
49.	Sacred Heart	0
50.	St. Catherines	34,966
51.	St. Lukes	31,035
52.	St. Jospeh's	7,661
Intermediary Total		$ 174,556
7.	**Blue Cross and Blue Shield of Michigan**	
53.	Henry Ford	301,324
54.	Sparrow	149,457
55.	Providence	243,178
56.	St. Jospeh's	144,231

** The Hospital is not identified and preliminary results are not included in this report because of an ongoing OIG review. The Hospital was judgmentally selected.

57.	Marquette General	$ 57,069
58.	Ingram Medical Center	13,155
59.	Hutzel	168,791
60.	Crittenton	37,929
Intermediary Total		$1,115,134
8.	**Blue Cross and Blue Shield of Oklahoma**	
61.	St Francis	191,684
62.	Baptist Medical Center of Oklahoma	38,968
63.	South Community	8,542
64.	Mercy Health Center	7,880
65.	Oklahoma Osteopathic	70,329
66.	Muskogee Regional Medical Center	10,386
67.	Jane Phillips Memorial Medical Center	9,870
68.	Deaconess Hospital	2,990
Intermediary Total		$ 340,649
9.	**Blue Cross of California**	
69.	University of California San Francisco	127,420
70.	St. John's Hospital and Health Center	130,189
71.	University of California San Diego	97,280
72.	Tri-City Medical Center	473,864
73.	Little Company of Mary Hospital	256,216
74.	Northridge Hospital and Medical Center	347
75.	Mission Hospital Medical Center	138,171
76.	Paralta	108,626
Intermediary Total		$1,332,113
TOTAL MEDICARE OVERPAYMENTS TO HOSPITALS		$8,548,679***

*** Only 71 of the 76 hospital had Medicare overpayments which they had not refunded.

APPENDIX B

PREVIOUSLY ISSUED OIG MSP RELATED REPORTS

1. *Survey of the Tax Equity and Fiscal Responsibility Act of 1982*, March 1984, ACN-03-42009.

2. *Medicare Secondary Payer Provision End-Stage Renal Disease*, August 1984, 1-07-4001-14.

3. *Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota*, November 1984, 1-08-4009-14.

4. *Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado*, December 1984, 1-08-4001-14.

5. *Medicare Secondary Payer Provision End-Stage Renal Disease*, April 1985, 1-07/08-4002-14.

6. *Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota*, May 1985, 03-08-5001-14.

7. *Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon*, May 1985, 3-10-4008-14.

8. *Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts*, June 1985, 1-01-4105-31.

9. *Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts*, June 1985, 1-01-4105-32.

10. *Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri*, December 1985, 3-07-5001-32.

11. *Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado*, December 1985, 3-08-5002-14.

12. *Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts*, November 1985, OPI-85-7-040.

13. *Medicare Secondary Payer Provision Working Aged in Missouri*, July 1986, P-07-86-00079.

14. *Medicare Secondary Payer Provision Working Aged in Colorado*, July 1986, P-07-86-00071.

15. *End Stage Renal Disease MSP Review*, August 1986, P-01-86-00103.

16. *Medicare Overpayments for Services Provided to Beneficiaries with End Stage Renal Disease*, April 1987, A-10-86-62003.

17. *Retirees of Exempt State and Local Government Could Cost Medicare $12.8 Billion over the next 5 Years*, September 1987, A-09-86-62050.

18. *Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years*, December 1987, A-10-86-62016.

19. *Medicare as a Secondary Payment Source - End State Renal Disease*, January 1988, OAI-07-86-00092.

20. *Medicare as a Secondary Payment Source for Automobile Accident Related Claims*, January 1988, OAI-07-86-00017

21. *Medicare as a Secondary Payment Source - Medicare Beneficiaries Covered By Employer Group Health Plans*, February 1988, OAI-07-86-00091.

22. *Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985*, April 1988, A-10-86-62005.

23. *Medicare as Secondary Payer - A Restitution Proposal*, February 1990, AO-12-89-00002.

24. *More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program*, March 1990, A-09-89-00100.

25. *MSP Survey - Contractors Questionnaire*, November 1990, A-09-89-00151

26. *Overview of Medicare Secondary Payer Systems: Strategies for Improvement*, January 1990, OAI-07-90-00740.

27. *Medicare Secondary Payer: Unrecovered Funds*, August 1991, OEI-07-90-00764.

28. *Medicare Prepayment Review: MSP Procedures at Carriers*, August 1991, OEI-07-89-01683.

29. *Extent of Unrecovered Medicare Secondary Payer Funds*, August 1991, OEI-07-90-00760.

30. *Medicare Secondary Payer: Effectiveness of Current Procedures*, August 1991, OEI-07-90-00761.

31. *Medicare Secondary Payer: Effectiveness of First Claim Development*, November 1991, OEI-07-90-00763.

32. *Review of Aetna Life Insurance Company's Compliance with Working Aged Provisions of the MSP Program for the Period January 1, 1988 thru December 31, 1989*, February 1992, A-01-90-00509.

33. *Medicare as a Secondary Payer, Nationwide Employer Project*, July 1992, A-09-89-00162.

34. *Review of Selected Part B MSP Activities at Blue Shield of Florida*, April 1992, A-04-91-02004.

35. *Medicare as a Secondary Payer - Review of HCFA's Efforts to Implement the Data Match Project*, August 1992, A-09-91-00103.

36. *Review of Empire Blue Cross Blue Shield Compliance with the Medicare Secondary Payer Legislation*, October 1992, A-02-91-01054.

37. *Review of Blue Cross Blue Shield of Michigan Compliance with the Medicare Secondary Payer Legislation*, March 1993, A-05-92-00099.

38. *Provident Life and Accident Insurance Company - Medicare Secondary Payer*, December 1993, A-04-92-02049.

39. *Follow-up Audit of the Health Care Financing Administration's Resolution of the Office of Inspector General Recommendation Relating to Employer Compliance with the Medicare Secondary Payer Data Match Project*, February 1994, A-02-93-01017.

WASHINGTON POST
December 23, 1993 -- p.B1, B6

GU Medical Center To Pay $2.4 Million In Medicare, Penalties

Reimbursement to U.S. Part of National Audit

By Michael York
Washington Post Staff Writer

Georgetown University Medical Center has agreed to pay the federal government $2.4 million in reimbursements and penalties for retaining excess Medicare payments, hospital and government officials said yesterday.

The payment, the largest of its kind by an area hospital, is a result of a nationwide audit by the Department of Health and Human Services that was started last year after officials reported that the government was losing hundreds of millions of dollars a year. The payment is part of a settlement scheduled to be announced today by U.S. Attorney Eric H. Holder, whose office negotiated the agreement.

The government's audit found that in some instances from 1986 to 1991, the hospital collected payments from both the Medicare system and a private insurer. Under federal law, Medicare is a secondary insurer—it covers bills for elderly people without private insurance or bills that exceed the limits of private insurance plans.

Dan Oldani, Georgetown hospital's administrator, said the payment reflects $1.6 million in excess payments retained by the hospital plus a 50 percent penalty of $800,000. Oldani said the hospital already has repaid almost $1 million, and he said the entire amount will be repaid by July 1994.

Georgetown was singled out in the audit because it regularly counted as income the money that it owed to Medicare. Another, broader investigation by the inspector general of Health and Human Services, the department responsible for administering Medicare, concluded that hospitals nationwide held about $266 million in 1991 in overpayments owed to Medicare.

Oldani said the excess payments to Georgetown actually reflected a small percentage of total Medicare accounts during the five years covered in the audit. About 27 percent of the hospital's patients are Medicare patients, Oldani said, and the total amount of Medicare billings ranged from about $45 million in 1986 to more than $80 million in 1991.

Oldani said the repayment "will be a challenge" for the financially strapped medical center, which has laid off some employees during the last year.

Federal officials familiar with the department's investigation said Georgetown's problems stemmed from inadequate bookkeeping controls and apparently were not intentional. In addition, officials said Georgetown cooperated with their investigation.

Hospital officials said last year that Georgetown's policy was to advise the government of the overpayments and await requests for reimbursement. After 90 days, the hospital said, it included the overpayments in its general income.

Under its agreement with the government, Georgetown has promised to revamp its billing and collection system to eliminate much of the opportunity for it to retain excess payments.

See MEDICARE, B6, Col. 1

MEDICARE, From B1

The question of how hospitals bill for their services and how the government and private insurers pay for those services has been a longstanding source of controversy within the medical community. The excess payments made by Medicare are only a part of the problem, according to health care specialists, many of whom say the bulky, unwieldy billing systems used by many large hospitals contribute to the rising cost of medical care.

Last year, for example, Washington Hospital Center estimated that it held almost $3 million in excess payments made by private insurers. However, the hospital said its policy is to return such overpayments only after it is notified and reimbursement is requested.

It could not be determined last night whether other area hospitals are under investigation.

Mr. DINGELL. Thank you, Ms. Brown.

The Chair is going to recognize members in the order of their appearance. First, the gentleman from Colorado. Do you have an opening statement you would like to submit for the record?

Mr. SCHAEFER. I thank the Chair and apologize for being a bit late. I do have an opening statement I would like to submit for the record.

Mr. DINGELL. Without objection that will be inserted in the record at the appropriate point.

[The prepared statement of Mr. Schaefer follows:]

STATEMENT OF HON. DAN SCHAEFER

Thank you, Mr. Chairman. Today's hearing continues this subcommittee's long-running examination of the hospital industry's financial practices.

A little over 2 years ago we heard about Humana Hospital's pricing policies, which involved routinely overcharging by large amounts on ancillary items like bedpans, crutches and other supplies, while at the same time undercharging on hospital room rates. Humana's chairman and other witnesses told the subcommittee that Humana was not alone in its pricing endeavors—that it was in fact only following the practice of the industry in general, both for-profit and nonprofit.

We saw this "everybody's doing it" practice again several months later, when looking at the related issues of credit balances, double billing and other bookkeeping methods employed by the hospital industry. At that hearing we discovered a number of hospitals nationwide owing hundreds of millions of dollars to the Medicare program—moneys which they had held onto, and even counted as income on their books, simply because no one from the Federal Government had ever made any attempt to collect them.

I understand the HHS Office of Inspector General has made a concerted effort to remedy this situation, and I look forward to hearing how successful those efforts have been. I also hope we can get a commitment to seek even further improvements in collecting the huge sums due to the Federal Government through Medicare credit balances. I want to welcome the Inspector General, Ms. June Brown, to your first, and most assuredly not last, appearance before this subcommittee, and I look forward to your testimony.

Thank you, Mr. Chairman.

Mr. DINGELL. The Chair now recognizes the gentleman from California for questions.

Mr. MOORHEAD. Well, thank you, Mr. Chairman. You know, during this time when we are discussing an actual health bill, I have had a chance to go around to many of my health-giving institutions to find out how things are working with them at the present time. One thing they tell me is that when MediCal and Medicare is involved, the government negotiates with the hospital about the amount that they will pay on the bill, rather than just paying the amount that it comes to and their share of it.

As a result, they cheat the other patients in the hospital by making them pay larger amounts in order to balance the accounts of the hospital and the insurance companies. I know that that's difficult. Most of these are nonprofit institutions, so there is no profit there, and they have to go out to the community to raise money when the government does that.

I think one of the things that causes these problems you have discussed is that many times the hospitals and the insurance companies feel that they have been cheated out of money by the government as they have negotiated these things and they have to do something to get their money back.

I don't know that that's true, but I know there are a lot of hard feelings and they don't particularly like MediCal or Medicaid or

Medicare patients because they know the government is not going to pay what the true costs are.

Ms. BROWN. To the best of my knowledge, they don't negotiate the amounts but there are set amounts for a set procedures. Some hospitals, of course, charge differently than others and an average is taken for that area to determine what the amount is.

Mr. HAPCHUK. Yes. Under the Medicare Program with the DRG system, which was implemented in 1983, we basically have uniform rates that the hospital industry does not negotiate. Under the Medicaid Program in California, I believe there is negotiation by the hospitals.

Mr. MOORHEAD. I know they would negotiate the same thing if there wasn't.

Mr. HAPCHUK. But with respect to Medicare, we have done a series of reviews on the profit margins of hospitals. What we basically found in the beginning of the prospective payment system is that, again taking hospitals as an average, there were profits being made by a large number of hospitals in the system.

In recognition of our work and the work done by the General Accounting Office and the work done by the Health Care Financing Administration, I think if you go back and take a look at congressional action you can see that the update factor to these initial rates basically has been such that right now I believe that the hospital industry on Medicare has indicated it is around break even with respect to treating Medicare patients.

Mr. MOORHEAD. Well, I don't have very many proprietary hospitals. They are mostly run by church organizations or nonprofit agencies of one kind or another, and those are basically the ones that have been complaining to me about what has happened to them. When that happens, it is certainly unfair to the paying patients in the hospital who naturally feel the effect of higher charges that have to be made in order to balance things out.

Mr. HAPCHUK. It certainly is a problem. If we go back and take a look why Congress implemented the Prospective Payment System in 1983, they were concerned about the huge increases in health care costs and a technique was used, basically, to average the costs. When you come with any type of an average, certain people are above the average with cost and a reimbursement to them may not be sufficient to cover their cost. But this was designed, basically, to put a cap on things, and it is an averaging process.

Mr. MOORHEAD. When you are in an area like Los Angeles, the Los Angeles area, prices are a lot more expensive than they are other places too.

At our last hearing on this issue that we are dealing with today, the Inspector General cited circumstances where a hospital attempted to return a payment to the intermediary but was unable to do so. Does this situation still exist; if so, what is being done about it?

Mr. HAPCHUK. HCFA has issued instructions right now informing the fiscal intermediaries when somebody comes with a refund to them to immediately take it. What happened at the time when Mr. Kusserow was here is that HCFA was trying to get a complete package. It did not want to take the money without what they are going to call an adjustment bill, and that caused some delays.

Well, quite frankly, right now the philosophy at HCFA is to take the money and then work with the particular hospital to get all of the adjustment information and process that. So in answer to your question, that situation has been eliminated.

Mr. MOORHEAD. Good. What actions are you taking toward the intermediaries both to make sure that Medicare is reimbursed for overpayments and to prevent such situations from reoccurring?

Mr. HAPCHUK. This is for the intermediaries?

Mr. MOORHEAD. Yes.

Mr. HAPCHUK. Are we dealing with the credit balances?

Mr. MOORHEAD. No.

Mr. HAPCHUK. What we are doing right now is HCFA has instituted a centralized monitoring facility whereby it is going to the hospitals and asking them to report their credit balances to them on a quarterly basis. If a hospital fails to report it, HCFA sends them a notification in letter form asking for their compliance, and if need be can go through and impose some sort of penalty against them. What this is basically doing is we have a large number of hospitals reporting, and I believe we can see the ramifications since HCFA has already collected approximately $584 million.

Mr. MOORHEAD. You testified last year that the Office of Inspector General generated savings, fines, restitutions, penalties, and receivables of over $61 million—$61 dollars for every Federal dollar invested in this operation. Are you able to use these moneys to further fund enforcement practices?

Ms. BROWN. Unfortunately, no. We are strictly confined to the budgeted amount for our office. Even in a case such as Georgetown University, where a substantial amount was awarded by the judge to pay for the cost of the investigation, that money did not come back to the Inspector General Office.

Mr. MOORHEAD. The General Fund?

Ms. BROWN. Well, I believe it went back to Medicare in that case. The funding of our office has very little to do with the results of our work.

Mr. MOORHEAD. You testified last year that you obtained 1,406 successful prosecutions and imposed 956 administrative sanctions. It sounds like a lot, but how does it compare to previous years?

Ms. BROWN. That is down a little from previous years, but it is quite in proportion with the cuts in our staff. I reviewed that carefully when I came into this job—I was confirmed November 6—to see what the results were of the cutbacks and whether or not there had been a substantial impact on the work. There have been some declines in the result of our work, but I think that it has not been beyond what would be expected for the kind of cutback we have had.

Mr. MOORHEAD. I see our good chairman has the gavel ready to pound the desk and the red light on, so I have taken the hint, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The gentlewoman from Pennsylvania?

Ms. MARGOLIES-MEZVINSKY. Thank you, Mr. Chairman.

In your testimony you stated that $624 million in Medicare credit balances have been identified and more than $584 million has been recovered; is that correct?

Ms. BROWN. That's correct.

Ms. MARGOLIES-MEZVINSKY. What is primarily responsible for the credit balances that existed in the past and that exist now?

Mr. HAPCHUK. Really, when you take a look at it, I think there are two main things that cause credit balances. When we did our analysis we found that many of them were related to MSP situations. This is a situation where care is given to a Medicare patient and the hospital sends a bill to both Medicare and a private insurer, and both pay the bill. That was the primary reason.

The other primary reason that we found was duplicated payments, whereby the Medicare fiscal intermediary had made two payments for the same service. Again, we have to realize that hospitals a very complex situation. Many times with various codes it can change one little item and send the same bill in, and it's not going to be picked up by the fiscal intermediary. That was the second largest item that we had.

We also had a couple of other things. We had some outpatient services that were inappropriately put on the inpatient bill and reimbursed by Medicare. That was another one that we have done a series of reviews on. Basically, the two reasons I have described were the primary causes for the credit balances.

Ms. MARGOLIES-MEZVINSKY. Could you give me an indication as to what percentage is a coding problem, comes from coding problems?

Mr. HAPCHUK. We indicated in the testimony that 11 percent was made by miscellaneous errors made for the most part by the fiscal intermediaries. The coding problem I mentioned about the outpatient service constituted 3 percent of the overpayments. For services that were not performed but billed, it was 7 percent; and the remaining were the two reasons I described to you.

Ms. MARGOLIES-MEZVINSKY. In your testimony you indicated that in one of your reviews 52 of the hospitals unsuccessfully attempted to refund some Medicare overpayments to 8 of 9 fiscal intermediaries. What were the impediments to the hospital successfully refunding this money to the fiscal intermediaries?

Ms. BROWN. Well, that problem has been corrected. The problem at that time was when money was just coming back without some kind of a statement to show how they calculated the amount and where the errors had occurred. HCFA didn't know what to do with the money, and they were waiting for the accompanying accounting data. They have changed their policy now. They take the money and they hold that in reserve and then they ask for the other information and then close it out as they get that.

Ms. MARGOLIES-MEZVINKSY. They didn't send it back, however? They just didn't know what to do with it; correct?

Ms. BROWN. That's right. They didn't know how to actually put it into their records. They didn't have a holding account to account for that at that time, but they have changed that policy now.

Mr. DINGELL. They do have that now?

Ms. BROWN. Yes, they do have that where they can hold that in reserve until they are able to calculate the reasons for this payment back.

Mr. DINGELL. Thank you.

Ms. MARGOLIES-MEZVINSKY. Who do you think bears the primary responsibility for the problems that exist?

Ms. BROWN. Well, as I mentioned in my opening statement, this is the most complicated area I have run into, and I have been Inspector General of four agencies including Defense, which has some very complicated problems as well. It is a matter of a huge number of separate accounts and separate payees here and trying to collect information on a voluntary basis from all of the various people that are involved in this.

There needs to be some much more structured way of HCFA accumulating the data so that they know who has outside insurance as well as when that changes. Many of these people in Medicare that are over 65 years old change jobs frequently, too, or they are working on a temporary job of some type, and so they may get insurance for a short period. Most of the data that is collected, even with some of our newest procedures, is historical in nature. The fact that they might have some indication to show somebody has outside insurance doesn't necessarily mean that is the current case.

They are also very concerned about holding payments so that a provider would suffer because they are not receiving a payment and in their zeal for getting payments made on a timely basis, they have frequently made those payments when an insurer is also responsible for it.

Ms. MARGOLIES-MEZVINKSY. Where do you think plain old-fashioned greed enters this equation?

Ms. BROWN. Well, greed is probably part of it. When Congressman Moorhead mentioned that some of the hospitals felt justified in keeping the extra payment because they were limited in an unfair way in the amount that they could recover from an Medicare patient, they felt that the specified amount for a given procedure was not sufficient and that was a justification, I don't feel that's a justification.

If there is a duplicate payment, why then they should recognize that as they would with any private patient and refund that money to the appropriate secondary payer. There are hospitals that do that. There was a hospital in Anne Arundel County that was doing a very good job of identifying duplicate payments in our review, so they would refund the money as it was received. A great many of them did not, and they used as a reason that they would wait until somebody came back and collected that money.

That puts all of the burden on HCFA who has limited information, limited resources to do the research with, and they in turn have to identify this outside of that accounting mechanism that is available to the hospitals, and they are unable to keep up with it.

Ms. MARGOLIES-MEZVINSKY. In your estimation, what are the overpayments by Medicare to the fiscal intermediaries? What are they on a yearly basis? What is your estimate of them?

Ms. BROWN. The total amount?

Ms. MARGOLIES-MEZVINSKY. Yes.

Ms. BROWN. Well, we were talking about—you know, it is again a guess, but I would assume about $1 billion.

Mr. DINGELL. A billion?

Ms. BROWN. Yes.

Ms. MARGOLIES-MEZVINSKY. Is that for me?

Mr. DINGELL. No. The red light tells us both.

Ms. MARGOLIES-MEZVINKSY. Thank you very much.

Ms. BROWN. I think that's quite possible. But again, we haven't got a handle on the entire amount.

Ms. MARGOLIES-MEZVINSKY. Thank you.

Mr. DINGELL. The Chair thanks the gentlewoman.

The gentleman from Colorado?

Mr. SCHAEFER. Thank you, Mr. Chairman.

Ms. Brown, you testified that HCFA agreed with your recommendation to perform an evaluation of the State Medicaid agencies' oversight activities of hospitals' procedures over Medicaid credit balances in the timely refunding of overpayments. Has this evaluation been performed?

Mr. HAPCHUK. Yes, we are in the process of doing that. We have sent questionnaires out to the 50 States, and so far we have received 29 replies from the States and we are in the process of evaluating them. We have found a couple of things. Only nine of the States have written procedures for identifying and recovering Medicaid overpayments. Now, we are going to try to see how that impacts on the actual collection.

What we are basically doing is we thought that HCFA had done such a very nice job of monitoring the Medicare collections we were using that as sort of a model to go out and see how States were picking up the Medicaid collections. Some of the States, North Carolina I believe was one of them, have a system that sort of more or less mirrors what HCFA is doing. We recognize that States do have the freedom of different ways of doing it, so we are in the process right now of seeing what they are doing and how successful they have been.

Mr. SCHAEFER. What is the time frame on completion of this?

Mr. HAPCHUK. We should get back all of the replies, I would think, within a month. We will then start evaluating the replies and then, quite frankly, I think that in certain cases we are going to have to actually send our auditors out on site to get additional information. That is the part I really do not know how long it is.

What we are trying to do is basically provide technical assistance to the States that they can go back and get that money which certainly a portion comes back to the Federal Government; but again, a large amount comes back to the State governments, you know, for their Medicaid programs.

Mr. SCHAEFER. For both of you, you testified that of the estimated $73 million Medicaid credit balances outstanding, $31 million are State funds and——

Mr. HAPCHUK. Yes.

Mr. SCHAEFER. I'm sorry?

Mr. HAPCHUK. Yes, sir.

Mr. SCHAEFER. Given the current financial situation of most of our States, it is in their best interest to certainly work with the feds to ensure that this problem is resolved. Are the States really working with you on this regard?

Mr. HAPCHUK. Yes. Typically, when we go out and do reviews of States, it's not an adversarial relationship. We go out, and especially for something like this which actually, quite frankly, is at least a potential financial gain to them, by and large they are very

appreciative of our efforts. We frequently provide technical assistance to States, as in the Medicaid Drug Rebate Program which was enacted by Congress. And like with every new program, let's face it, there were problems with it. We are actively working with a lot of the State audit organizations to combine our talents and their talents to ensure that refunds come back in.

Mr. SCHAEFER. Your survey said that 29 States had responded to your survey. Are you doing anything to the other States or recontacting them?

Mr. HAPCHUK. Certainly. We recognize that a lot of times when a letter comes through sometimes it can get inadvertently put on somebody's desk and forgotten. What we will try to do is to do a personal contact with the people and try to solicit the replies that way. I would expect, quite frankly, that we will receive replies from everybody.

Mr. SCHAEFER. Is the writing off of credits a common, accounting tool, or is it unique to the hospital industry?

Mr. HAPCHUK. Well, I think when we come up with credit balances, we have to recognize that just because you have a credit balance does not necessarily mean that something is wrong. The fact is when we did our review on the Medicare side, we found out that about 50 percent of them were overpayments to Medicare.

The other problem, then, is you have accounting errors. We have to realize that we have large institutions and you have a massive charge structure putting items onto the patient account, and, quite frankly, sometimes errors are made. It is the responsibility of the billing department of that hospital when it sees an account that looks funny—and, let's face it, a credit balance looks funny—to basically go review the account and take the appropriate action. So many times when it is an accounting error, it will get zeroed out only because it was incorrectly made the first time.

Mr. SCHAEFER. This whole set of problems regarding keeping overpayments, credit balances, et cetera, it's not unique to the hospital industry, I don't believe. Did you find this in other areas as well?

Mr. HAPCHUK. I think our review on this was strictly with hospitals, but I think you probably have billing problems in any type of business affair.

Mr. SCHAEFER. You have been an IG in other areas, Ms. Brown.

Ms. BROWN. Yes. When there is a credit balance, which essentially means that on an account receivable you have received more money than you expected to receive, there is certainly something wrong. Now, a normal procedure would be to discover what happened, determine whether somebody was paid twice or some bill was paid twice or whether there was some other error, and to try to clear that up. I am sure that in all businesses you can only go so far, and then you would write off small discrepancies.

I do believe, though, that with the prevalence of this type of thing and the amount of these bills in each account, that in most cases it is quite a conscious effort or policy to let those balances rise, and then when they close out their books for the end of the year, they can just eliminate that or put it into an income account. Speaking as a CPA who kept books for many years, I can't see how that could be done unknowingly.

Mr. SCHAEFER. I see. Thank you.

Mr. DINGELL. If the gentleman would yield?

Mr. SCHAEFER. Go ahead.

Mr. DINGELL. Why did you say you can't see how it could be done unknowingly?

Ms. BROWN. If you had large numbers of credit balances in accounts that you would recognize that people were either being overbilled or that there was duplicate billing or there was some kind of a problem, and you would not just consider that income to the organization without recognizing that you were collecting money that was inappropriately collected.

Mr. DINGELL. If the gentleman would yield further?

Mr. SCHAEFER. Certainly, Mr. Chairman.

Mr. DINGELL. What is done to address that question? It would appear at the year's end if people were simply folding in these credit balances, you could deal with that somewhat by requiring a report at year end as to credit balances at year end, could you not, or require a monthly statement of that so that you could identify whether, in fact, these credit balances were building either over a month's time or over a year's time or both?

Mr. HAPCHUK. I agree with you. This is why HCFA has put in a quarterly requirement for reporting credit balances. Also, in answer to your question, I agree with you. At the end of the year most hospitals hire a CPA firm to come in and take a look at financial statements. Credit balances are these funny looking accounts, and as an auditor that would be one of the first things I would look at because it looks different.

Mr. DINGELL. Ought that not then be reported, and ought we not then require that a copy of that the year end report of the accountant be submitted to HCFA or to your office or to somebody in government?

Ms. BROWN. Well, the quarterly reports that HCFA is now requiring should provide for that.

Mr. DINGELL. Should?

Ms. BROWN. Well, yes.

Mr. DINGELL. It should do that.

Ms. BROWN. It is a rather new requirement. It is also making the institutions very aware of the fact that we are requiring that information and that they need to look at those accounts, that it is inappropriate to just write them off or put them into an income account.

Mr. DINGELL. Does that statement that it is inappropriate to simply write them off appear in the regulations anywhere?

Ms. BROWN. I don't recall that it is.

Mr. HAPCHUK. I don't believe it is that specific.

Ms. BROWN. However, it is very clear that the money should be returned.

Mr. DINGELL. My dearly beloved friend, it is very clear but it is not sufficiently clear that they were doing it over time. As a matter of fact, you have cited either somewhere between a quarter of a billion a year and a billion a year that is not returned. What I'm trying to see is how are we going to encourage the hospitals to understand that they have an overpayment here that should be returned. We have discussed reporting, making available copies of the year-

end audit by the CPA, requiring periodic reporting of credit balances and things of that kind on either a monthly, quarterly, or an annual basis. I don't sense that you are telling me that any of that is being done by HCFA or by HHS.

Ms. BROWN. Well, the quarterly reporting is now being done, but that is a rather new procedure.

Mr. DINGELL. But does that include the credit balances?

Ms. BROWN. Yes.

Mr. DINGELL. It does?

Ms. BROWN. Yes. Yes, it does.

Mr. DINGELL. Well, I'm going to ask the staff to communicate with you about my concerns on how these things should, perhaps, be more fully and completely and vigorously addressed.

I thank the gentleman.

Mr. SCHAEFER. My time has expired, Mr. Chairman.

Mr. DINGELL. The Chair recognizes himself.

Did you find that the profit motive was in any way involved in the existence of or in the cancellation or folding in of the credit balances?

Mr. HAPCHUK. Well, certainly whenever we have a credit balance that basically gets zeroed out and the money is not returned to Medicare, that would increase the profitability of the institution.

Mr. DINGELL. Would you say that this was an innocent increase in profitability, or was it perhaps maybe something that was enjoyed a little more than is really necessary?

Mr. HAPCHUK. Well, in answer to your question, in 1986 we issued a report where we first identified credit balances. We thought that, basically, the problem had been solved.

Mr. DINGELL. We find here in 1994 that the problem still exists.

Mr. HAPCHUK. That's what has us concerned.

Mr. DINGELL. That would tend to indicate it has not been solved.

Mr. HAPCHUK. That is true, and that we agree with you on. Specifically, to go through and prove that they were basically on purpose to do it, for most of the ones that we looked at, I don't think we could make quite that thing. There was always a reason why.

Mr. DINGELL. Would making this behavior subject to penalties be a good step?

Ms. BROWN. I think there are several things that could be done, and part of it is there is no penalty that is provided. In the case of Georgetown, we did get a substantial penalty in our settlement agreement in order to close out that case. For the most part, there aren't treble damages or double damages or anything like that so if something is identified——

Mr. DINGELL. You do apparently have the ability to level a civil penalty, do you not, HHS does, HCFA? Who has the authority to level civil penalty and what civil penalty?

Ms. BROWN. In that case, do you know the civil penalty?

Mr. HAPCHUK. No.

Mr. DINGELL. See, I'm both pleased and displeased. Georgetown is a school that both my wife and I went to. We are very proud of it. We think it is a wonderful school and we happen to think the hospital is a superb hospital. We think that it is appropriate that they should give back their credit balances. We even think that

probably it was appropriate that they should have to pay a civil penalty.

My question is, it appears that others are not paying civil penalties, so that distresses me. So I find my school is paying civil penalties and other schools are not paying civil penalties. Shouldn't we be addressing this in a more uniform and evenhanded fashion?

Ms. BROWN. I agree with you, Mr. Chairman. We are now working on some provisions both voluntary disclosure, some additional types of penalties and so on that we may ask this committee to support. Some of it will be require some legislative changes but I do think——

Mr. DINGELL. We are open and ready for business on legislative changes that stops defalcation of public funds, and look with some hope and interest on your supporting those suggestions at an early time.

Does the credit balance issue exist for other health care providers such as nursing homes and home health agencies?

Mr. HAPCHUK. Yes, sir. We did a review on nursing homes and found to a limited extent that there were credit balances on those.

Mr. DINGELL. Has this been gone into?

Mr. HAPCHUK. Yes, sir. We issued a report and are monitoring it. When we did our review, we did not find the magnitude of the credit balance problems on the other providers to the extent that we found it on hospitals.

Mr. DINGELL. Well, it appears that there is need for some addressing of this question through changes in regulations, better reporting, and perhaps some modest penalties to provide a small inducement towards better behavior. Am I correct in that appreciation or not?

Ms. BROWN. I certainly feel you are correct, Mr. Chairman. I think that normally when these things are identified there is no penalty no matter how long the money has been kept.

Mr. DINGELL. It's a funny thing, we run into that all the time. It's sort of catch me if you can. If I get the money, I go off with it and I enjoy myself mightily in the process; if I get caught, all I've got to do is give it back. There is no pain factor associated with that. It does occur to me that good behavior and proper behavior by the honest and ethical people in the business ought to be rewarded by at least the confidence that everybody else, whether they like it or not, is behaving the same way. Is that incorrect?

Ms. BROWN. I think you're absolutely correct, sir.

Mr. DINGELL. I suspect that the committee will be sending a little letter to Secretary Shalala on that, and perhaps with a copy to you and then we perhaps will be holding some discussions on how this matter can be best corrected to abate a problem which we find is of some concern to the committee.

Now, is there any penalty in the regulations now for maintaining credit balances? None?

Ms. BROWN. No, there is no penalty.

Mr. DINGELL. I understood that there was a possibility that there was, in fact, a penalty for such behavior.

Is it correct that there is an incentive or a conflict of interest on the part of hospitals to maintain credit balances rather than to report or avoid them?

Mr. HAPCHUK. Yes, sir. Whenever we have a credit balance on that, let's face it, the hospital is keeping money that belongs to somebody else, and to that it's financial gain to them. There is a disincentive for them to send it back because it will be money that they can basically use for other purposes, if they so desire, or be given back to somebody else.

Mr. DINGELL. You indicated in the case of hospitals it runs about $1 billion a year. Would I be fair in inferring that somewhat similar level would be there with regard to behavior by nursing homes, home health care agencies? They seem to be likely candidates for doing this too, because we have had to look at them a time or two. Is there a possibility that they would be engaged in this practice?

Ms. BROWN. When I responded to that, I was responding that the overall MSP problem could come up to $1 billion a year.

Mr. DINGELL. Up to $1 billion?

Ms. BROWN. Yes.

Mr. DINGELL. That is a nice number.

Ms. BROWN. I think if you look at all of them. Now, I don't have a statistical projection that would say that, but just from looking at the pervasive nature of this in those areas that we have looked at.

Mr. DINGELL. I think we ought to ask the head of HCFA or perhaps the Secretary to come up and talk with us about this, so we can have an exchange of views and a little discussion of these amounts to get the regulatory process going better?

Ms. BROWN. I would like the opportunity to develop some proposals that I could discuss with them, and then I would certainly welcome a hearing.

Mr. DINGELL. I would suggest that it would be good that you were going to do so with all diligence and suitable, appropriate speed, and then we would of course indicate that we were anxious to hear from them so that they could discuss what they were doing about your recommendations in light of the fact that this is perhaps costing the taxpayers $1 billion a year.

Well, the Chair's time has expired. The Chair recognizes the gentleman from Ohio.

Mr. BROWN. Thank you, Mr. Chairman.

Ms. Brown, in your testimony you mentioned that the government has recovered over $584 billion in credit balances. None of that includes interest on the money; correct?

Ms. BROWN. No, that is not including interest.

Mr. BROWN. You identified some $624 million in Medicare credit balances and there was no interest paid on that also. How much interest would that be? Have you calculated any of those figures?

Mr. HAPCHUK. No, we have never calculated anything like that, because that would be determined somewhat the age of the credit balances. Some of them are more than 1 year old. We know that from our review. We have never attempted to come up with an imputed interest.

Mr. BROWN. Maybe this question is just too obvious, but wouldn't compelling health care providers to pay interest accrued on MSP overcharges and Medicare credit balances be an incentive for health care providers to avoid overbilling the government to begin with?

Ms. BROWN. As I just mentioned, right now there is no penalty and I think interest plus some type of penalty would be appropriate.

Mr. BROWN. Can that be made unilaterally? Who can make that determination to set up that penalty schedule and to charge interest? Does that need to be an act of Congress?

Mr. HAPCHUK. We would have to go and check with legal counsel on that. I'm not too sure if it would require legislation or if it could be done by a regulation. We will have to get back to you on what would have to be done.

Mr. BROWN. A couple of years ago Mr. Kusserow recommended quarterly reporting of balances and changes in accounting procedures to require audit firms to review credit balances and interest to be collected on balances. What happened to those recommendations?

Ms. BROWN. The quarterly report is now required and the firms are supposed to review credit balances along with their audits. I don't know about the interest, though.

Mr. HAPCHUK. The interest I do not believe was ever put up in either proposed legislation or through the Department.

Mr. DINGELL. Would the gentleman yield?

Mr. BROWN. Yes.

Mr. DINGELL. They file a quarterly report, yet the process and the problem of these credit balances persist. What happens to this quarterly report that is filed? Is it reviewed by anybody, or does it go directly to the archives where they treat it with usual tender care?

Mr. HAPCHUK. No, HCFA is reviewing the quarterly reports because they are trying to figure out if some of the hospitals are not reporting. If a hospital does not report, HCFA basically contacts them, and if need be can apply some sort of a sanction to them to try to motivate them to report.

Mr. DINGELL. You say they can, but do we have an appreciation that they are requiring a report? Are these voluntary reports? Is there some enforcement to assure that the reports are filed? What percentage of the hospitals are reporting? I detect from your comments that perhaps—I sense that perhaps the majority of the hospitals may not be reporting at all.

Mr. HAPCHUK. No, sir. We have some statistics that most of the hospitals are reporting. There are some that have not reported.

Mr. DINGELL. What percentage would be that are not reporting?

Mr. HAPCHUK. I do not have their percentage, but figuring that there are around 6,000 hospitals. We sent potential suspension letters to around 1,800, and so far HCFA has implemented around 400 payments suspensions.

Mr. DINGELL. Four hundred payment suspensions. It sort of seems to me that, perhaps, maybe a more careful review would indicate that the committee should, either in the course of consideration of health care legislation or in addressing the problem of reconciliation and the budget perhaps put some helpful language in there to assure that there is encouragement for the hospitals to report or more encouragement to report truthfully. Am I correct in that appreciation?

Ms. BROWN. Yes, sir.

Mr. DINGELL. I sort of sensed that.

Ms. BROWN. One of the problems in reviewing——

Mr. DINGELL. Should I ask the staff to communicate with you about some language on this or perhaps with the general counsel at HHS, because I know their enthusiasm rises as we send them letters.

Ms. BROWN. I would appreciate having the opportunity to work something out, and I would like to work with your staff in a preliminary way.

I want to say that credit balances, some of the offenders have written off the account so they don't have credit balances, and we are concerned about that as well. At least those hospitals who maintain the balance, there is something for us to go in and research.

Mr. DINGELL. Maybe we need to assure that credit balances are not written off. Is there a regulation on that point, or would that be helpful?

Ms. BROWN. To my knowledge there is no regulation against that.

Mr. HAPCHUK. There is no regulation.

Mr. DINGELL. We seem to have carelessness on three levels here. I apologize to the gentleman for using his time, but it appears that HHS and HCFA are not doing a good job of keeping track of these reporting requirements or addressing the problem of overpayments through the cancellation of credit balances. It doesn't seem that they are spending as much time as they should on getting and reviewing these reports because, as you say, there is perhaps $1 billion a year owed to the taxpayers.

It appears also that there are some problems with the intermediaries who are refusing to take back moneys or to properly audit the people they are supposed to audit. They have an audit responsibility, do they not?

Ms. BROWN. They do.

Mr. DINGELL. Am I on track so far? Is this, generally, a correct appreciation?

Ms. BROWN. Yes, sir.

Mr. DINGELL. Well, then that leads us to hospitals who are also getting these credit balances and I gather enjoying them mightily as they cancel them at your end and fold them into other things. We have three sets of people who are either being careless and enjoying it or perhaps dishonest and enjoying it or perhaps incompetent and enjoying it. My question is, what is it that we do to help these people to do a better job and to have a cleaner conscience and to feel better about their responsibility for public money?

Mr. HAPCHUK. Well, I think we tried to address some of that in our report because in addition to going back and asking HCFA to have the intermediaries go back and collect the money, we made certain procedural recommendations to try to prevent this from happening in the future. And I think you hit on one of them. HCFA does have what we call the provider audit function.

Mr. DINGELL. You are actually paying the intermediaries to make payments and also to audit, are you not?

Mr. HAPCHUK. Yes, sir.

Mr. DINGELL. I assume that we must assume that the intermediaries are doing their job properly. As a matter of fact, they are even paid a certain amount for auditing, are they not?

Mr. HAPCHUK. Yes, sir.

Mr. DINGELL. But apparently they are not. Now, so we've got hospitals and intermediaries who are not doing their jobs. Should we perhaps cut off some from participation in the program? Perhaps, tell the intermediaries, "We are going to have new intermediaries do this auditing because we know they will be more enthusiastic about it"? Or should we say to the hospitals, "Perhaps maybe you don't like our business, and therefore I will go to somebody who will comply with our regulations"?

Ms. BROWN. Well, this is a logical step that could be taken.

Mr. DINGELL. You pay these intermediaries $2 billion a year, do you not?

Ms. BROWN. That's right.

Mr. DINGELL. That's just for administrative functions?

Ms. BROWN. Yes, sir.

Mr. DINGELL. Well, I've consumed vastly overmuch time of the gentleman from Ohio, and I apologize to him and I recognize him again.

Mr. BROWN. Thank you, Mr. Chairman.

Let me kind of get a better grasp on some of these issues. The MSP problem obviously has been around for a long time. The estimate is the incorrect Medicare payments continue to range to upwards of $1 billion a year. Why isn't that number decreasing over time?

Mr. HAPCHUK. Well, I think you have to recognize that there is a variety of players, and everybody has to do their part to clear up the situation. Let me explain some of the players who need to be actively engaged.

I think one of the people we have to start with is the beneficiary. You see, on the claim form, the claim form has been used for years, they ask you if you have other insurance information. We have always thought that if every beneficiary would put that information in there at least we would have a chance of not creating a Medicare secondary payer problem.

Now, in addition, when the beneficiary goes into, say, the hospital, the hospital is supposed to go through and ask for other insurance information. This requirement has been around for a long time such that if the beneficiary forgets to put it on a claim form or tell somebody the provider does. Again, we come through and after we have a Medicare bill the intermediary is supposed to go through and process the claim and to take a look at all this information and to see if, in fact, it's an indication of private insurance in other places. So it has to get involved with it.

Last but not least, I think the Federal Government has to get with it. In the Health Care Financing Administration at one time had a proposal whereby it was going to require our contractors to match Medicare payments with its private insurance enrollment information. So if we have everybody doing that, I would think that the thing has to be reduced. The problem is we are getting various people who are not doing it.

Ms. BROWN. In the thing that was just mentioned by John where we ask the intermediaries to look at their private side, OBRA 1989 prohibited HCFA from requiring that. Now, that was a very obvious type of internal control mechanism; so, there have been obstacles to getting these corrective actions underway.

Mr. BROWN. Is HCFA doing enough?

Ms. BROWN. I think HCFA has made a lot of improvements. In the material I have reviewed in looking into this issue that they have taken a great many steps. I don't think we can say they are doing enough or we are doing enough or that we have had all of the appropriate legislation as long as we still have this very, very serious and extensive problem.

Mr. BROWN. Your office has been active in suggesting solutions. What do you think would be most effective in correcting the existing problems in the MSP programs, specifically?

Ms. BROWN. Well, the one I just mentioned, having the files matched when there is an intermediary and having a private side. I think that restriction should be removed. I also think there should be some penalty and interest charges when an organization maintains a credit balance and doesn't take the time to do research and find out where that's due. Some organizations are maintaining them for long periods of time. That way you can look at it and they say, "We haven't used that money, it's still sitting there." They have identified it, and they are waiting for someone to collect.

Mr. DINGELL. Would the gentleman yield?

Mr. BROWN. Yes.

Mr. DINGELL. You have raised an exciting prospect here. How long have these credit balances been existence, and how long have these people been canceling them out at year end?

Ms. BROWN. Well, they don't all cancel them at year end. Some of them maintain them in some kind of a credit balance account and some are writing them off. In some cases, we have found there has been deliberate writing off and deliberate obstructing of the audit trail, and in those cases of course we have been able to impose penalties. So it varies a great deal. This is not a simple solution, and all companies aren't doing the same thing or in the same way.

Mr. DINGELL. In our discussion of these amounts we were up to about a billion and a quarter a year, total?

Ms. BROWN. I think you've raised it.

Mr. DINGELL. Well, I started out with a quarter of a billion, then I heard a billion, and then I heard that the quarter of a billion was additive and not included. I'm just trying to get an idea of the magnitude of this.

Ms. BROWN. No, sir, I don't think I said it was additive.

Mr. DINGELL. I want to see how much we can help public-spirited citizens return to the Treasury.

Mr. HAPCHUK. Well, I think what we have in here is—let me try to separate the two ideas right now.

Mr. DINGELL. Well, I've got $1 billion on MSP, and a quarter of a billion on credit balances. Now, do I add those or subtract them?

Mr. HAPCHUK. While there is some duplication, I believe add them.

Ms. BROWN. Merge them, sir.

Mr. DINGELL. Well, if we went back over 10 or 15 years we would be talking about $10 billion.

Ms. BROWN. Oh, some of it is carryover, without doubt. I don't say that's new every year that much money is——

Mr. DINGELL. I apologize to the gentleman again.

Mr. BROWN. That's all right, Mr. Chairman.

You mentioned in your testimony and in your response to a couple of questions the matching of records. Why do you think that the contractors have an inherent conflict of interest in identifying instances where Medicare should have paid secondary? Explain that conflict of interest precisely, if you would.

Ms. BROWN. I was confused by that, too, sir. Apparently, they feel there is a conflict of interest with their shareholders because moneys would be identified that they otherwise would be able to keep and it would increase their profit margin.

They feel that simply because they have this separate function that they shouldn't be made to look at their own function as a provider and have to compare those accounts with credit balances, and perhaps be at a disadvantage compared to others who were also performing this kind of accounting manipulation.

Mr. BROWN. You mentioned reviewing the creation of voluntary disclosure and recovery program for MSP. Would you tell us about that proposal?

Ms. BROWN. There was a proposal that was developed I believe it was about 1990, and I think that needs to be updated. It was never implemented or carried further. I have been in this position just a few months. I feel there are some very good ideas in that, and I have some additional ones from my review of this matter. We are now working on that to come up with a program, and also working in conjunction with a task force that we have been participating with, with the Department of Justice on health care fraud.

We are looking at various places where there are opportunities for voluntary disclosure, where we could give people certain advantages in disclosing their own areas, where there is some kind of money that has been inappropriately used by an organization or kept by that organization without being penalized.

We feel that our resources are extremely limited, that we may be able to, in addition to the kind of work we are doing in fraud and audit and so on, that we could extend the capability of our office a great deal by motivating people to give us feedback and providing a way for them to gracefully repay the HHS in various specialties, and this is one of them.

Mr. BROWN. No further questions, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman from Ohio.

You said something in your statement, you said, and I'm reading at page three:

"HHS can impose civil monetary penalties, CMP's, pursuant to the Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a. The OIG is also responsible for implementing the Secretary's authority for excluding fraudulent or abusive providers from participation in Federal health care financing programs."

I sense that nobody has ever been excluded because of either abuse or fraud; is that right?

Mr. HAPCHUK. We do have the exclusion authority. While I do not have the statistics here, I believe we have excluded people.

Mr. DINGELL. You have?

Mr. HAPCHUK. Yes.

Mr. DINGELL. I am comforted to hear that. Could you tell us what, in fact, has been done in this regard? I want you to understand, I am not critical of you. I am just trying to find out if the authorities are being used to the degree in which they should be.

Ms. BROWN. Well, we have extensive exclusion authorities, and we have used those. I can get you the facts on that which I would provide you separately. There are some authorities, particularly those that HCFA has the power to enforce that they have not yet set up a mechanism——

Mr. DINGELL. They have not yet set up a mechanism?

Ms. BROWN [continuing]. For implementing some of their authorities.

Mr. DINGELL. The staff will be in contact with you. Could you give us a brief appreciation of what authorities they have, what authorities that don't have and need, where HCFA has set up a mechanism and a framework and structure to utilize those authorities? I think that would be an interesting evening's reading for us.

Ms. BROWN. Yes, sir, I will provide that.

Mr. DINGELL. Ms. Brown, Mr. Hapchuk, the committee thanks you.

The Chair wants to commend the staff. This is the most remarkable hearing we have had because I'm out at the appointed hour, which I had never anticipated would happen during my service as chairman of this subcommittee.

The Chair thanks you both for your assistance to us. The committee stands adjourned to the call of the Chair.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

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